SEVEN SUMMITS
Therapy & Fitness, LLC

992 Old Eagle
School Rd
Wayne, PA 19087
(610) 687-2776

To ensure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you.

NAME _____ LEISURE ACTIVITIES _____
OCCUPATION: _____

ALLERGIES: List any medication/s you are allergic to: _____
Are you latex sensitive? Yes No List any other allergies we should know about _____
Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please check ( ) any of the following whose care you're under

☐ Medical doctor (MD) ☐ Psychiatrist/Psychologist Other _____
☐ Osteopath ☐ Physical Therapist _____
☐ Dentist ☐ Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

_____
_____

Have you EVER been diagnosed as having any of the following conditions?

☐ YES ☐ NO Cancer. If YES, describe what kind: _____
☐ YES ☐ NO Heart Problems
☐ YES ☐ NO High blood pressure
☐ YES ☐ NO Circulation problems
☐ YES ☐ NO Asthma
☐ YES ☐ NO Emphysema/Bronchitis
☐ YES ☐ NO Chemical dependency (i.e., alcoholism)
☐ YES ☐ NO Thyroid problems
☐ YES ☐ NO Diabetes
☐ YES ☐ NO Multiple sclerosis
☐ YES ☐ NO Rheumatoid arthritis
☐ YES ☐ NO Other arthritic conditions
☐ YES ☐ NO Depression
☐ YES ☐ NO Hepatitis
☐ YES ☐ NO Tuberculosis
☐ YES ☐ NO Stroke
☐ YES ☐ NO Kidney disease
☐ YES ☐ NO Anemia
☐ YES ☐ NO Epilepsy
☐ YES ☐ NO Other

During the past month have you been feeling down, depressed or hopeless? ☐ YES ☐ NO
During the past month have you been bothered by having little interest or pleasure in doing things? ☐ YES ☐ NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in anyway? ☐ YES ☐ NO
FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ YES ☐ NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE REASON FOR SURGERY/HOSPITALIZATION

1. _____ _____ 2. _____ _____
3. _____ _____ 4. _____ _____
5. _____ _____ 6. _____ _____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

☐ YES ☐ NO Diabetes
☐ YES ☐ NO Tuberculosis
☐ YES ☐ NO Heart disease
☐ YES ☐ NO High blood pressure
☐ YES ☐ NO Stroke
☐ YES ☐ NO Kidney disease
☐ YES ☐ NO Alcoholism (chemical dependency)
☐ YES ☐ NO Cancer
☐ YES ☐ NO Arthritis
☐ YES ☐ NO Anemia
☐ YES ☐ NO Headaches
☐ YES ☐ NO Epilepsy
☐ YES ☐ NO Mental illness

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

☐ YES ☐ NO Aspirin
☐ YES ☐ NO Tylenol
☐ YES ☐ NO Advil/Motrin/Ibuprofen
☐ YES ☐ NO Laxatives
☐ YES ☐ NO Decongestants
☐ YES ☐ NO Antihistamines
☐ YES ☐ NO Antacid
☐ YES ☐ NO Vitamins/mineral supplements
☐ YES ☐ NO Other _____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____
How many packs of cigarettes do you smoke a day? _____
How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you recently noted?

☐ YES ☐ NO weight loss/gain
☐ YES ☐ NO nausea/vomiting
☐ YES ☐ NO dizziness/lightheadedness
☐ YES ☐ NO fatigue
☐ YES ☐ NO weakness
☐ YES ☐ NO fever/chills/sweats
☐ YES ☐ NO numbness or tingling

_____ _____ _____ _____
Therapist signature Date Patient signature Date

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SEVEN SUMMITS THERAPY & FITNESS, LLC

PRIMARY INSURANCE- We will bill your primary insurance as a courtesy to you. We assume payment of insurance benefits is not forthcoming on charges older than 60 days. Charges outstanding for more then sixty days will be due in full from you regardless of the type of insurance involved. Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your insurance benefits. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. Secondary insurance will be your responsibility to file and collect.

MEDICARE- We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

SELF PAY- Please pay the balance in full at the time of service or upon the receipt of a monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that SEVEN SUMMITS THERAPY & FITNESS, LLC is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection.

WORKERS' COMP- We will bill your Workers' Comp carrier for your charges. Please note that you will remain financially responsible for all your charges if your carrier denies coverage.

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to SEVEN SUMMITS THERAPY & FITNESS, LLC in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (12% annually) for unpaid balances over 30 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of SEVEN SUMMITS THERAPY & FITNESS, LLC as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment expecting acts of negligence.

Patient Signature_____ Date _____

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SEVEN SUMMITS THERAPY & FITNESS, LLC
NOTICE OF PATIENT INFORMATION PRACTICES - THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS FORM CAREFULLY.

OUR LEGAL DUTY - SEVEN SUMMITS THERAPY & FITNESS, LLC is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES OF HEALTH INFORMATION - SEVEN SUMMITS THERAPY & FITNESS, LLC uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, audit tracking, and research studies. In any other situation, SEVEN SUMMITS THERAPY & FITNESS, LLC will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted for public view. You may request a copy of our Notice of Information Practices at any time. Our HIPAA Compliance Officer is Brady O'Mara. He can be reached at the office by calling (610) 687-2776.

PATIENT'S INDIVIDUAL RIGHTS - You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for treatment, payment, or other related administrative purposes. You may request in writing that we do not use or disclose your personal health information for treatment, payment, or administrative purposes except when specifically authorized by you, when required by law, or in an emergency. SEVEN SUMMITS THERAPY & FITNESS, LLC will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLAINTS - If you are concerned that SEVEN SUMMITS THERAPY & FITNESS, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Brady O'Mara. You may also send a written complaint to the U.S. Department of Health and Human Services.

Patient Signature:_____Date:_____